

Path2Health/CMSP

DRUG FORMULARY

Administered by MedImpact

January 2012

INTRODUCTION

Foreword

This document represents the efforts of MedImpact and the County Medical Services Program (CMSP) Governing Board to provide physicians and pharmacists with a method to evaluate the various drug products available under Path2Health and CMSP. The medical treatment of patients is frequently related to the practical application of drug therapy. Due to the vast availability of medication treatment modalities, a reasonable program of drug product selection and drug usage must be developed. The goal of the Path2Health/CMSP Drug Formulary is to enhance the ability of physicians and pharmacists participating in Path2Health and CMSP to provide optimal cost effective drug therapy for Path2Health and CMSP members.

The development, maintenance, and improvement of the Path2Health/CMSP Drug Formulary is evolutionary and requires on-going oversight. This is accomplished by a pharmacy and therapeutics review process conducted by a panel of physicians and pharmacists. The Path2Health/CMSP Drug Formulary is a continuously reviewed and revised list of drug products that reflects the consensus clinical opinion of the panel. Using this Formulary, you are encouraged to review the information and provide input and comments to the CMSP Governing Board.

Path2Health and CMSP use the following criteria in the evaluation of product selection for the Path2Health/CMSP Drug Formulary:

- The drug product must demonstrate unequivocal safety for medical use.
- The drug product must be efficacious and be medically necessary for the treatment, maintenance or prophylaxis of the medical condition.
- The drug product must demonstrate therapeutic marker outcomes accepted by the medical community.
- The drug product must be accepted for use by the medical community.
- The drug product should have a favorable cost ratio for the treatment of the medical condition.

How to Use the Drug Formulary

The Drug Formulary is a list of covered and preferred drug agents for Path2Health and CMSP members. All products are listed by their generic names, and most common proprietary (branded) name. The Drug Formulary may be accessed by using the index, both by generic and proprietary name (in small capital letters) and by therapeutic drug category. Any product not found in this Formulary listing, or any Formulary updates published by the CMSP Governing Board, shall be considered a Non-Formulary Drug.

All drugs are listed in each category in ascending order of cost. This is denoted by the relative dollar scale, described as follows:

\$	least expensive
\$\$	slightly more expensive
\$\$\$	more expensive
\$\$\$\$	significantly more expensive
\$\$\$\$\$	most expensive

The prices used to calculate the relative dollar scale are based on the monthly cost of therapy or cost of treatment course to allow for dosing interval differences between various products. The number of dollar signs is a relative indication of cost and does not represent the true cost of the drug. For example, two dollar signs do not mean that a product is twice as expensive as a product with one dollar sign. They are intended only to provide relative information regarding cost.

Economics should not be the only factor involved with any therapeutic and clinical decision process. Price comparisons are reflective of pricing and contracts available through MedImpact and the CMSP Governing Board.

Coverage Limitations

The Drug Formulary does not provide information regarding the specific coverage or limitations an individual member may have. Path2Health members have no share of cost or co-payment for covered prescription drug services. Some CMSP members may have specific limitations, such as share of cost, which are not reflected in the Drug Formulary. This Drug Formulary contains only FDA approved outpatient drugs for eligible members, and does not apply to non-FDA approved drugs or medications used in in-patient settings. If a Path2Health or CMSP member has any specific questions regarding coverage, they should contact the CMSP Governing Board at (916) 649-2631 for further explanation of benefits.

Outside of California and the designated border state areas of Oregon, Nevada and Arizona, Path2Health members are eligible to receive emergency prescription drug services from MedImpact's national network of contracting pharmacies in the US states or US Territories if the Path2Health member received treatment from a hospital emergency department.

CMSP members are not eligible to receive emergency prescription drug services outside of California and the designated board state areas of Oregon, Nevada and Arizona.

Generic Substitution

When available, FDA approved generic drugs are to be used in all situations, regardless of the brand name indicated. The brand names listed are for reference use only, and do not denote coverage, unless specifically noted. Greater economy is realized through the use of generic equivalents. This policy is not meant to preclude or supplant any state statutes that may exist. All drugs that are or become available generically are subject to review by the Path2Health/CMSP pharmacy and therapeutics review process.

Path2Health/CMSP approves such multisource drugs for addition to the maximum allowable cost (MAC) list based on the following criteria:

- A minimum of one "A" rated source of the product.
- An FDA Rating for generic equivalency.
- Review by CMSP Governing Board for efficacy and safety.
- Certain drug products with complex pharmacokinetics, dosage forms, narrow therapeutic efficacy or where blood level maintenance is crucial will not be subject to substitution. These products are:

- ◊ Coumadin
- ◊ Dilantin
- ◊ Lanoxin
- ◊ Premarin
- ◊ Neoral Oral Solution
- ◊ Synthroid

This list is reviewed and updated periodically based on the clinical literature and available pharmacokinetic principals of the drug products. If a physician determines that there is a documented medical need for the brand equivalent, a request for coverage may be made using the medication request process.

Preferred Branded Interchange

Certain multisource branded drug products may be excluded from coverage.

Experimental Drugs

The experimental nature or use of drug products will be determined by Path2Health/CMSP using current medical literature. Any drug product or use of an existing product, which is determined to be experimental, will be excluded from coverage.

Prior Authorization

Drug products that are listed as Prior Authorization (PA) required require approval when the member presents a prescription to a network pharmacy. To obtain coverage, the prescribing physician may:

- A. Fax a completed Medication Request Form (MRF) to MedImpact at (858) 790-7100, or
- B. Contact MedImpact at (800) 788-2949 and provide all necessary information requested.

If the request does not meet the criteria established by Path2Health/CMSP, the request will be denied and alternative therapy may be recommended. Each request will be reviewed on individual patient need and approval may be given if a documented medical need exists.

Request Process for Non-Formulary Agents

Coverage for non-formulary agents may be requested in advance by physicians. When a Path2Health or CMSP member gives a prescription order for a non-formulary drug to a pharmacist, the pharmacist should notify the physician and member of the nonformulary status. The physician, pharmacist or member may then call MedImpact at (800) 788-2949 to initiate the medical exception process. To obtain coverage, the prescribing physician may:

- A. Fax a completed Medication Request Form (MRF) to MedImpact at (858) 790-7100, or
- B. Contact MedImpact at (800) 788-2949 and provide all necessary information requested.

The following general criteria are used for approval.

- 1) The use of Formulary Drug Products is contraindicated in the patient.
- 2) The patient has failed an appropriate trial of Formulary or related agents.
- 3) The choices available in the Drug Formulary are not suited for the present patient care need, and the drug selected is required for patient safety.
- 4) The use of a Formulary Drug may provoke an underlying condition, which would be detrimental to patient care.

Path2Health/CMSP recognizes that not all medical needs can be met with agents listed in this document and encourages inquiries about optional therapies.

Step Care Agents

Drug products defined as step care will undergo an electronic pre-authorization process per Path2Health/CMSP guidelines, which requires a trial of first-line drug(s) before a Step Care drug will be covered at the formulary brand level. If recommended guidelines for first-line therapy are not met, then the Step Care drug may be subject to review through the prior authorization process.

Quantity Limits

Limitations on quantity may be placed on certain products due to safety, therapeutic or cost-effectiveness considerations. Prescriptions for such agents exceeding the quantity limit (QL), will be subject to the prior authorization process.

Appeals Process

Prior authorization and medical exception requests are evaluated based on medical necessity and safety as described. In the event of denial, providers or Path2Health and CMSP members may request a formal appeal verbally or in writing within sixty (60) days of denial notification. To request an appeal, call (800) 788-2949 or send your written appeal request to the following address:

MedImpact Healthcare Systems, Inc.
10680 Treena Street, 5th Floor
San Diego, CA 92131
Attention: Appeals Coordinator
or
Fax (858) 790-6060

Formulary Process and Communication

The Path2Health/CMSP Drug Formulary is a tool to promote cost-effective prescription drug use. While every attempt has been made to create a document that meets all therapeutic needs, the art of medicine makes this a formidable task. Path2Health/CMSP welcome input on the formulary from physicians and pharmacists providing services to Path2Health and CMSP clients. Suggestions and comments should be submitted to the CMSP Governing Board at the following address:

CMSP Governing Board
ATTN: Pharmacy and Therapeutics Panel
1451 River Park Drive, Suite 222
Sacramento, CA 95815
(916) 649-2631

Prescription Coverage of Select Drug Classes

There are certain prescription coverage differences between Path2Health and CMSP. The following table summarizes these differences. Details of prescription coverage by drug class are available in the main section of the printed formulary.

	Path2Health Members	CMSP Members
HIV Antiretroviral Agents	HIV antiretroviral agents are a prescription benefit. Fuzeon requires prior authorization approval. Path2Health members are not required to apply to ADAP.	HIV antiretroviral agents are not covered unless the member is not eligible for the AIDS Drug Assistance Program (ADAP). Evidence of ADAP ineligibility for antiretroviral coverage is required. Contact ADAP at (888) 311-7632 or (888) 575-2327 for more information. A Record of Denied Program Eligibility form must be completed and submitted to CMSP for antiretroviral coverage. This form can be obtained on the CMSP website: www.cmspcounties.org .
Contraceptives	Contraceptives are not a covered benefit. Path2Health members are referred to Family PACT. Contact Family PACT at (800) 942-1054 for more information.	Contraceptives are not covered unless the member is not eligible for Family PACT. Evidence of Family PACT ineligibility for contraceptive coverage is required. Contact Family PACT at (800) 942-1054 for more information. A Record of Denied Program Eligibility form must be completed and submitted to CMSP for contraceptive coverage. This form can be obtained on the CMSP website: www.cmspcounties.org .
Hemophilia Agents	Blood products are a covered benefit and require prior authorization.	Blood products otherwise available through the Genetically Handicapped Persons Program (GHPP) program are not a covered benefit unless the member is not eligible for GHPP. Evidence of GHPP ineligibility is required. Contact GHPP at (800) 639-0597 for more information. A Record of Denied Program Eligibility form must be completed and submitted to CMSP for medication coverage. This form can be obtained on the CMSP website: www.cmspcounties.org .
Hepatitis C: Ribavirin and Pegylated Interferons	These agents are a covered benefit and require clinical prior authorization. Members are not required to apply to the manufacturers' patient assistance programs.	These agents are not covered a covered benefit unless the member is not eligible for a drug manufacturer's patient assistance program and clinical prior authorization requirements are met. Evidence of ineligibility for the drug manufacturers' patient assistance program must be completed by the manufacturer and submitted to MediImpact.
Hepatitis C: Incivek (telaprevir) and Victrelis (boceprevir)	These agents are not a covered benefit. These agents may be available through the manufacturers' patient assistance program. Additional information about drug company patient assistance programs is available on the internet at www.pparx.org .	These agents are not a covered benefit. These agents may be available through the manufacturers' patient assistance program. Additional information about drug company patient assistance programs is available on the internet at www.pparx.org .

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CENTRAL NERVOUS SYSTEM AGENTS

Analgesic and Anti-Inflammatory Agents

Non-Steroidal Anti-Inflammatory Agents

FIRST LINE AGENTS

\$	Aspirin	ASPIRIN
\$	Aspirin EC	ECOTRIN
\$	Ibuprofen	MOTRIN (INCLUDES OTC)
\$	Ketoprofen	ORUVAIL, 200MG STRENGTH NON-FORMULARY
\$	Naproxen	NAPROSYN
\$	Naproxen Sodium	ANAPROX
		ANAPROX DS
\$	Piroxicam	FELDENE
\$	Salsalate	DISALCID
\$\$	Indomethacin	INDOCIN; INDOCIN SUPPOSITORIES NON-FORMULARY
\$\$	Diclofenac Sodium	VOLTAREN
\$\$	Etodolac	LODINE
\$\$	Fenoprofen	NALFON
\$\$	Meloxicam Tablets	MOBIC (TABLETS ONLY), SUSPENSION NON-FORMULARY
\$\$	Sulindac	CLINORIL
\$\$\$\$	Indomethacin, Sustained Release	INDOCIN SR

SECOND LINE AGENTS

SE	\$\$	Nabumetone	RELAFEN, STEP THERAPY , RESTRICTED TO A TRIAL OF 2 UNRESTRICTED NSAIDS IN THE PAST 90 DAYS
SE	\$\$\$	Etodolac Extended Release	LODINE XL, STEP THERAPY , RESTRICTED TO A TRIAL OF 2 UNRESTRICTED NSAIDS IN THE PAST 90 DAYS
SE	\$\$\$\$	Diclofenac/Misoprostol	ARTHROTEC, STEP THERAPY , RESTRICTED TO A TRIAL OF A FORMULARY NSAID IN THE PAST 90 DAYS
PA	\$\$\$\$	Celecoxib	CELEBREX, PA REQ

Miscellaneous Arthritis Agents

Migraine Agents

	\$\$	Leflunomide	ARAVA
	\$	APAP/Dichloralphenazone/Isomethep	MIDRIN
	\$	Butalbital/APAP/Caffeine	ESGIC
	\$	Butalbital/Aspirin/Caffeine (Tablets Only)	ESGIC PLUS
	\$\$	Ergotamine/Caffeine	FIORICET
QL	\$\$\$	Sumatriptan	FIORINAL
			CAFERGOT
			IMITREX, LIMITED TO 4 INJECTIONS, 9 TABLETS, OR 6 NASAL UNITS PER MONTH, ONLY 1 RX FOR ANY TRIPtan/MONTH, SUMAVEL NON-FORMULARY
SE, QL	\$\$\$\$	Almotriptan	AXERT, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF SUMATRIPTAN IN THE PAST 120 DAYS, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPtan/MONTH
SE, QL	\$\$\$\$	Eletriptan	RELPAX, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF SUMATRIPTAN IN THE PAST 120 DAYS, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPtan/MONTH
SE, QL	\$\$\$\$	Frovatriptan	FROVA, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF SUMATRIPTAN IN THE PAST 120 DAYS, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPtan/MONTH
SE, QL	\$\$\$\$	Naratriptan	AMERGE, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF SUMATRIPTAN IN THE PAST 120 DAYS, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPtan/MONTH

SE, QL	\$\$\$\$	Rizatriptan	MAXALT, MAXALT MLT, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF SUMATRIPTAN IN THE PAST 120 DAYS, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPtan/MONTH
SE, QL	\$\$\$\$	Zolmitriptan	ZOMIG, ZOMIG ZMT STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF SUMATRIPTAN IN THE PAST 120 DAYS, LIMITED TO 9 TABLETS OR 6 NASAL UNITS PER MONTH, ONLY 1 RX FOR ANY TRIPtan/MONTH
PA, QL	\$\$\$\$\$	Dihydroergotamine	MIGRANAL, PA REQ , LIMITED TO 1 KIT (4 TREATMENTS) PER MONTH
		Opiate Agonists	
QL	\$	Acetaminophen/Codeine	TYLENOL #2, #3, #4, LIMITED TO #240/MONTH OR 960ML/MONTH ; ORAL SUSPENSION AND VOPAC NON-FORMULARY
QL	\$	Acetaminophen/Hydrocodone	VICODIN, LIMITED TO #240/MONTH
QL			VICODIN ES, LIMITED TO #150/MONTH
QL			LORCET, LIMITED TO #240/MONTH
QL			LORTAB, LIMITED TO #120/MONTH
QL			LORCET PLUS, LIMITED TO #180/MONTH
QL	\$	Codeine/Aspirin	NORCO, XODOL, & ZYDONE NON-FORMULARY
QL	\$	Oxycodone/Acetaminophen	EMPIRIN #2, #3, #4, LIMITED TO #240/MONTH
QL			PEROCET, LIMITED TO #240/MONTH; MAGNACET AND PRIMALEV NON-FORMULARY
QL	\$	Oxycodone/Aspirin	TYLOX, LIMITED TO #240/MONTH
QL	\$	Propoxyphene Napsylate/APAP	PERCODAN, LIMITED TO #240/MONTH
QL	\$\$	Butalbital/APAP/Caffeine/Codeine	DARVOCET-N 100, LIMITED TO #180/MONTH ; DARVOCET A500 AND BALACET 325 NON-FORMULARY
QL	\$\$	Butalbital/Aspirin/Caffeine/Codeine	FIORICET/CODEINE, LIMITED TO #180/MONTH
QL	\$\$	Morphine	FIORINAL/CODEINE, LIMITED TO #180/MONTH
QL	\$\$	Oxycodone	MSIR, LIMITED TO #240/MONTH OR 960ML/MONTH
QL	\$\$\$	Hydromorphone	OXYIR, LIMITED TO #240/MONTH
QL	\$\$\$	Morphine SR	DILAUDID, LIMITED TO #240/MONTH OR 960ML/MONTH
QL	\$\$\$	Oxycodone	MS CONTIN/ORAMORPH SR, LIMITED TO #120/MONTH
PA, QL	\$\$\$\$\$	Oxycodone	OXYFAST, LIMITED TO #960ML/MONTH
PA, QL		Opiate Antagonists	OXYCONTIN, PA REQ , LIMITED TO #60/MONTH
	\$\$	Naltrexone	REVIA
		Miscellaneous Analgesics	
	\$	Acetaminophen	TYLENOL
	\$	Tramadol	ULTRAM ; ULTRAM ER NON-FORMULARY
PA, QL	\$\$\$	Butorphanol NS	STADOL NS, PA REQ , LIMITED TO 2 BOTTLES/MONTH
		Miscellaneous Central Nervous System Agents	
PA	\$\$\$\$	Donepezil	ARICEPT, PA REQ

Anticonvulsant Agents

Barbiturate Anticonvulsants

\$	Phenobarbital	PHENOBARBITAL
\$\$	Mephobarbital	MEBARAL
\$\$	Primidone	mysoline

Benzodiazepine Anticonvulsants

QL	\$	Clonazepam	KLONOPIN, LIMITED TO #90/MONTH; RAPDIS TABLETS NON-FORMULARY
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Hydantoin Anticonvulsants

\$\$	Phenytoin	DILANTIN, PHENYTEK
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Miscellaneous Anticonvulsants

\$	Carbamazepine	TEGRETOL; EQUETRO NON-FORMULARY
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	\$\$	Carbamazepine Extended Release	TEGRETOL XR
	\$\$	Divalproex Sodium	DEPAKOTE, DEPAKOTE ER NON-FORMULARY
PA	\$\$	Gabapentin	NEURONTIN, PA REQ
	\$\$	Valproic Acid	DEPAKENE
PA	\$\$\$	Lamotrigine	LAMICTAL, PA REQ , LIMITED TO #60/MONTH FOR 100MG AND 150MG, #180/MONTH FOR 25MG
PA, QL	\$\$\$	Topiramate	TOPAMAX, PA REQ , LIMITED TO #90/MONTH FOR 25MG, 50MG AND 100MG STRENGTHS
	\$\$\$\$	Oxcarbazepine	TRILEPTAL
	\$\$\$\$\$	Levetiracetam	KEPPRA
	\$\$\$\$\$	Tiagabine	GABITRIL

Antiparkinsonian Agents

\$	Amantadine	SYMMETREL
\$	Benztropine Mesylate	COGENTIN
\$	Trihexyphenidyl	ARTANE
\$\$	Carbidopa/Levodopa	SINEMET; PARCOPA NON-FORMULARY
\$\$	Selegiline 5mg Tablets	SELEGILINE 5MG TABLETS, SELEGILINE CAPSULES AND ZELAPAR NON-FORMULARY
\$\$	Ropinirole	REQUIP; REQUIP XL NON-FORMULARY
\$\$\$	Bromocriptine	PARLODEL
\$\$\$	Carbidopa/Levodopa CR	SINEMET CR
\$\$\$	Pramipexole	MIRAPEX

Muscle Relaxant Agents

Skeletal Muscle Relaxants

QL	\$	Baclofen	LORESAL
	\$	Carisoprodol	SOMA, LIMITED TO #120/MONTH; 250 STRENGTH NON-FORMULARY
	\$	Chlorzoxazone	PARAFON DSC
	\$	Cyclobenzaprine	FLEXERIL
	\$	Methocarbamol	ROBAXIN
	\$\$	Orphenadrine Citrate	NORFLEX
	\$\$\$	Dantrolene Sodium	DANTRIUM
	\$\$\$\$	Orphenadrine/Aspirin/Caffeine	NORGESIC

Psychotherapeutic Agents

Tricyclic Antidepressant Agents

\$	Amitriptyline	ELAVIL
\$	Amoxapine	ASENDIN
\$	Desipramine	NORPRAMIN
\$	Doxepin	SINEQUAN
\$	Imipramine	TOFRANIL, TOFRANIL PM NON-FORMULARY
\$	Maprotiline	LUDIOMIL
\$	Nortriptyline	AVENTYL
\$	Protriptyline	PAMELOR
		VIVACTIL

S.S.R.I. Agents

SE	\$	Fluoxetine	PROZAC (10MG, 20MG ONLY)
	\$	Citalopram	CELEXA
	\$\$	Paroxetine	PAXIL, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF <u>2</u> PREFERRED SSRI ANTIDEPRESSANTS (FLUOXETINE, CITALOPRAM) IN THE PAST 365 DAYS
	\$\$\$	Fluvoxamine	LUVOX

S.N.R.I. Agents

SE, QL	\$\$\$\$	Duloxetine	CYMBALTA, RESTRICTED TO USE AFTER A 30 DAY TRIAL OF A GENERIC SSRI ANTIDEPRESSANT, BUPROPION, OR TCA IN THE PREVIOUS 6 MONTHS, LIMITED TO #60/MONTH
PA, QL	\$\$\$\$	Venlafaxine	EFFEXOR, PA REQ, LIMITED TO #60/MONTH IF DOSE ≤ 200MG/DAY, LIMITED TO #90/MONTH OF DOSE > 200MG/DAY
PA, QL	\$\$\$\$	Venlafaxine Extended Release	EFFEXOR XR, PA REQ, LIMITED TO #30/MONTH IF DOSE ≤ 150MG/DAY, LIMITED TO #60 IF DOSE > 150MG/DAY; VENLAFAXINE EXTENDED RELEASE TABLETS NON-FORMULARY
M.A.O. Inhibitor Agents			
	\$\$	Phenelzine	NARDIL
	\$\$\$\$\$	Tranylcypromine	PARNATE
Miscellaneous Antidepressant Agents			
	\$	Bupropion	WELLBUTRIN, SR TABS, XL TABS, AND APLENZIN NON-FORMULARY
	\$	Clomipramine	ANAFRANIL
	\$	Trazodone	DESYREL
	\$	Mirtazapine	REMERON TAB, SOLTABS AND 7.5MG TABLETS NON-FORMULARY
MD, QL	\$\$	Nefazodone	SERZONE, RESTRICTED TO PSYCHIATRY, LIMITED TO #60/MONTH
Antimanic Agents			
	\$	Lithium Carbonate	ESKALITH LITHOBID
Benzodiazepines			
QL	\$	Alprazolam	XANAX, LIMITED TO #90/MONTH; XANAX XR, NIRAVAM, AND ALPRAZOLAM INTENSOL NON-FORMULARY
QL	\$	Clorazepate	TRANXENE, LIMITED TO #90/MONTH
QL	\$	Chlordiazepoxide	LIBRIUM, LIMITED TO #90/MONTH
QL	\$	Diazepam	VALIUM, LIMITED TO #90/MONTH, DIASTAT NON-FORMULARY
QL	\$	Flurazepam	DALMANE, LIMITED TO #30/MONTH
QL	\$	Lorazepam	ATIVAN, LIMITED TO #90/MONTH; LORAZEPAM ORAL CONCENTRATE NON-FORMULARY
QL	\$	Temazepam	RESTORIL, LIMITED TO #30/MONTH; 22.5MG STRENGTH NON-FORMULARY
QL	\$	Triazolam	HALCION, LIMITED TO #30/MONTH
Antipsychotic Agents			
	\$	Chlorpromazine	THORAZINE
	\$	Clozapine	CLOZARIL
	\$	Fluphenazine	PROLIXIN
	\$	Haloperidol	HALDOL, HALDOL DECANOATE-VIALS ONLY
	\$	Perphenazine	TRILAFON
	\$	Pimozide	ORAP
	\$	Thioridazine	MELLARIL
	\$	Thiothixene	NAVANE
	\$	Trifluoperazine	STELAZINE
	\$	Loxapine	LOXITANE
	\$\$	Molindone	MOBAN
QL	\$\$\$	Risperidone	RISPERDAL, LIMITED TO #60/MONTH
QL	\$\$\$\$	Quetiapine	SEROQUEL, LIMITED TO #90/MONTH, 25MG STRENGTH NON-FORMULARY. 25MG STRENGTH NOT COVERED FOR INSOMNIA, SUBMIT PA FOR OTHER INDICATIONS.
QL	\$\$\$\$\$	Aripiprazole	ABILIFY, LIMITED TO #30 PER MONTH DISCMELTS NON-FORMULARY
QL	\$\$\$\$\$	Asenapine	SAPHRIS, LIMITED TO #60 PER MONTH
QL	\$\$\$\$\$	Olanzapine	ZYPREXA, LIMITED TO #60/MONTH ZYPREXA ZYDIS, LIMITED TO #60/MONTH ZYPREXA INJECTION

QL	\$\$\$\$\$	Ziprasidone	ZYPREXA RELPREVV GEODON, LIMITED TO #60/MONTH
Antipsychotic/SSRI Combination Agents			
QL	\$\$\$\$\$	Olanzapine/Fluoxetine HCl	SYMBYAX, LIMITED TO #30/MONTH
Miscellaneous Anxiolytics, Sedatives, and Hypnotics			
	\$	Chloral Hydrate	NOCTEC
	\$	Hydroxyzine	ATARAX
	\$	Hydroxyzine Pamoate	VISTARIL
	\$	Promethazine	PHENERGAN
	\$	Buspirone	BUSPAR
QL	\$	Zolpidem	7.5MG STRENGTH NON-FORMULARY AMBIEN, LIMITED TO #14/MONTH, AMBIEN CR AND EDLUAR NON-FORMULARY

CARDIOVASCULAR/BLOOD AGENTS

Antiarrhythmic Agents

Antidysrhythmic Drug Agents

\$	Amiodarone	CORDARONE; 100MG STRENGTH NON-FORMULARY
\$	Disopyramide	NORPACE
\$	Procainamide	PRONESTYL
\$\$	Disopyramide CR	NORPACE CR
\$\$	Quinidine Gluconate	QUINAGLUTE
\$\$	Mexiletine	MEXITIL
\$\$	Propafenone	RYTHMOL
\$\$	Procainamide SR	PROCAN SR
		PROCANBID
\$\$	Quinidine Sulfate	CIN-QUIN
\$\$	Quinidine Sulfate SR	QUINIDEX
\$\$	Sotalol	BETAPACE
\$\$\$	Flecainide	TAMBOCOR
\$\$\$	Quinidine Polygalacturonate	CARDIOQUIN

Antihypertensive Agents

Alpha-Adrenergic Antagonist Antihypertensive Agents

\$	Reserpine	SERPASIL
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Beta-Adrenergic Antagonist Agents

\$	Propranolol	INDERAL
\$	Atenolol	TENORMIN
\$	Metoprolol Tartrate	LOPRESSOR
\$	Nadolol	CORGARD
\$	Pindolol	VISKEN
\$\$	Metoprolol Succinate	TOPROL XL
\$\$	Propranolol LA	INDERAL LA

Combination Alpha-Beta Antagonist Agents

\$	Carvedilol	COREG; COREG CR NON-FORMULARY
\$	Labetalol	NORMODYNE TRANDATE

Angiotensin Converting Enzyme Inhibitor Agents

\$	Benazepril	LOTENSIN
\$	Captopril	CAPOTEN
\$	Enalapril	VASOTEC
\$	Lisinopril	PRINIVIL ZESTRIL

Angiotensin Receptor Blocker Agents

SE, QL	\$\$\$	Olmesartan	BENICAR, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF AN ACE INHIBITOR IN THE PAST 90 DAYS
SE, QL	\$\$\$\$	Valsartan	DIOVAN, STEP THERAPY , LIMITED TO #60/MONTH, RESTRICTED TO USE AFTER A TRIAL OF AN ACE INHIBITOR IN THE PAST 90 DAYS

Calcium Channel Blocking Agents

\$	Diltiazem	CARDIZEM
\$	Verapamil	CALAN
\$\$	Amlodipine	NORVASC, LIMITED TO #30/MONTH
\$\$	Felodipine	PLENDIL, LIMITED TO #30/MONTH
\$\$	Diltiazem SR	CARDIZEM SR; CARDIZEM LA NON-FORMULARY
\$\$	Diltiazem CD	CARTIA XT
\$\$	Nifedipine, Sustained Release	ADALAT CC
\$\$	Verapamil LA Tablets	CALAN SR; COVERA-HS NON-FORMULARY
\$\$	Verapamil SR Capsules	VERELAN

Centrally Acting Antihypertensive Agents

\$	Clonidine	CATAPRES
\$	Guanfacine	TENEX
\$	Methyldopa	ALDOMET

Combination Antihypertensive Agents

\$	Atenolol/Chlorthalidone	TENORETIC
\$	Benazepril/HCTZ	LOTENSIN HCT
\$	Bisoprolol/HCTZ	ZIAC
\$	Captopril/HCTZ	CAPOZIDE
\$	Enalapril/HCTZ	VASORETIC
\$	Lisinopril/HCTZ	ZESTORETIC

SE, QL	\$\$\$\$	Olmesartan/HCTZ	BENICAR HCT, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF AN ACE INHIBITOR IN THE PAST 90 DAYS
SE, QL	\$\$\$\$	Valsartan/HCTZ	DIOVAN HCT, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF AN ACE INHIBITOR IN THE PAST 90 DAYS

Drugs for Pheochromocytoma

\$\$\$\$	Phenoxybenzamine	DIBENZYLINE
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Potassium-Sparing Diuretics

\$	Spironolactone	ALDACTONE
\$	Spironolactone/HCTZ	ALDACTAZIDE
\$	Triamterene 37.5mg/HCTZ 25mg	DYAZIDE
\$	Triamterene 37.5mg/HCTZ 25mg	DYAZIDE
\$	Triamterene 75mg/HCTZ 50mg	MAXZIDE 50
\$\$	Triamterene	DYRENIUM

Loop Diuretics

\$	Bumetanide	BUMEX
\$	Furosemide	LASIX

Thiazide and Related Diuretics

\$	Chlorthalidone	HYGROTON
\$	Hydrochlorothiazide (HCTZ)	HYDRODIURIL
\$	Indapamide	LOZOL
\$\$	Metolazone	ZAROXOLYN

Vasodilator Antihypertensive Agents

\$	Doxazosin Mesylate	CARDURA; CARDURAL XL NON-FORMULARY
\$	Hydralazine	APRESOLINE
\$	Minoxidil	LONITEN
\$	Prazosin	MINIPRESS

\$ Terazosin HYTRIN

Antilipemic Agents

\$	Gemfibrozil	LOPID
\$	Lovastatin	MEVACOR
\$	Niacin	NIACIN
\$	Simvastatin	ZOCOR, 80MG STRENGTH RESTRICTED TO PRIOR USE OF 80MG DUE TO MYOPATHY RISK; ALL OTHER STRENGTHS FORMULARY
SE	\$\$	Pravastatin PRAVACHOL STEP THERAPY, RESTRICTED TO USE AFTER A TRIAL OF SIMVASTATIN OR LOVASTATIN IN THE PREVIOUS 90 DAYS
	\$\$\$	Niacin, Delayed Release NIASPAN
	\$\$\$	Niacin/Lovastatin ADVICOR
QL	\$\$\$\$	Atorvastatin LIPITOR 40MG AND 80MG STRENGTHS ONLY, LIMITED TO #30/MONTH , LIPITOR 10MG AND 20MG NON-FORMULARY
	\$\$\$\$	Cholestyramine/Aspartame QUESTRAN LIGHT
	\$\$\$\$	Cholestyramine/Sucrose QUESTRAN

Blood Agents

Coagulants and Anticoagulants

\$	Warfarin Sodium COUMADIN
QL	\$\$\$\$ Enoxaparin LOVENOX, LIMITED TO #20/FILL TIMES 3

Hemorheologic Agents

\$\$ Pentoxifylline TRENTAL

Cardiac Glycoside Agents

\$ Digoxin LANOXIN; LANOXICAPS NON-FORMULARY

Antiplatelet Agents

\$ Dipyridamole PERSANTINE
\$\$ Cilostazole PLETAL
\$\$\$\$ Clopidogrel PLAVIX
\$\$\$\$ Pasugrel EFFIENT

Vasodilating Agents

\$	Isosorbide Dinitrate ISORDIL; CHEW TABLETS NON-FORMULARY
\$	Nitroglycerin Sublingual NITROSTAT SL
\$\$	Isosorbide Dinitrate SR DILATRATE SR
\$	Nitroglycerin Ointment NITROL
SE	\$\$ Isosorbide Mononitrate IMDUR, STEP THERAPY, RESTRICTED TO USE AFTER A TRIAL OF ISOSORBIDE DINITRATE OR ISOSORBIDE DINITRATE SR IN THE PAST 90 DAYS
	\$\$ Nitroglycerin Patches NITRO-DUR
	\$\$\$\$ Nitroglycerin Spray NITROLINGUAL SPRAY

GASTROINTESTINAL AGENTS

Antidiarrheal Agents

\$	Attapulgite	PAREPECTOLIN
\$	Bismuth Subsalicylate	PEPTO BISMOL
\$	Diphenoxylate/Atropine	LOMOTIL
\$	Kaolin/Pectin	KAOPECTATE
\$	Loperamide	IMODIUM

Antiemetic Agents

\$	Meclizine	ANTIVERT
\$	Metoclopramide	REGLAN
\$	Promethazine	PHENERGAN
\$\$	Prochlorperazine Maleate	COMPAZINE COMPAZINE SPANSULES NOT COVERED
PA	\$\$\$ Trimethobenzamide	TIGAN
PA	\$\$\$ Ondansetron Tablets	ZOFRAN TABLETS, PA REQ
PA	\$\$\$\$ Ondansetron ODT Tablets	ZOFRAN ODT, PA REQ
PA	\$\$\$\$\$ Ondansetron Solution	ZOFRAN SOLUTION, PA REQ

Antimuscarinic/Antispasmodic Agents

\$	Belladonna/Phenobarbital (Extentabs, Capsules Not Covered)	DONNATAL
\$	Dicyclomine	BENTYL
\$\$	Chlordiazepoxide/Clidinium	CHLORDIAZEPOXIDE/CLIDINIUM
\$\$	Hyoscyamine Sulfate	LEVBID LEVSIN LEVSIN SL

Antiulcer/Antipeptic Agents

\$	Antacid Mg OH/AI OH	MAALOX, TC
\$	Antacid Mg OH/AI OH/Simethicone	MYLANTA I, II
\$	Simethicone	MYLICON
\$\$	Omeprazole 20mg	PRILOSEC 20MG, OTHER STRENGTHS NON-FORMULARY
\$\$	Omeprazole Magnesium	PRILOSEC OTC
\$\$	Lansoprazole 15mg OTC	PREVACID 24HR, LEGEND LANSOPRAZOLE NON-FORMULARY
\$\$	Sucralfate	CARAFATE
\$\$	Misoprostol	CYTOTEC
SE, QL	\$\$\$ Pantoprazole	PROTONIX, STEP THERAPY , LIMITED TO A TRIAL OF OMEPRAZOLE AND LANSOPRAZOLE IN THE PREVIOUS 365 DAYS, LIMITED TO 30/MONTH

Bowel Evacuant Agents

QL	\$	Bowel Evacuation Prep Kits	FLEET PREP KIT 1, LIMITED TO #2 KITS/MONTH AND 4 FILLS PER YEAR
			FLEET PREP KIT 2, LIMITED TO #2 KITS/MONTH AND 4 FILLS PER YEAR
			FLEET PREP KIT 3, LIMITED TO #2 KITS/MONTH AND 4 FILLS PER YEAR

QL	\$	Enema	FLEET ENEMA, LIMITED TO #2 ENEMAS/MONTH AND 4 FILLS PER YEAR
	\$	Oral Colon Lavage Solution	COLYTE
QL	\$	Oral Saline Laxative	FLEET PHOSPHO-SODA, LIMITED TO #2 BOTTLES/MONTH AND 4 FILLS PER YEAR

Digestive Enzymes

\$\$	Amylase/Lipase/Protease	PANCRELIPASE 5,000
\$\$\$	Amylase/Lipase/Protease	CREON
\$\$\$	Amylase/Lipase/Protease	PANCREAZE

Gallstone Solubilizing Agents

\$\$	Ursodiol	ACTIGALL
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Gastrointestinal Stimulant Agents

\$	Metoclopramide	REGLAN
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H₂ Antagonist Agents

\$	Cimetidine	TAGAMET
\$	Famotidine	PEPCID
\$	Ranitidine	ZANTAC (TABLETS ONLY)

Laxative Agents

QL	\$	Bisacodyl Suppositories	DULCOLAX, LIMITED TO #30/MONTH
	\$	Docusate Sodium Capsules	COLACE
	\$	Sennosides	SENNNA
QL	\$\$	Lactulose	CEPHULAC, LIMITED TO 4L/MONTH
QL			CHRONULAC, LIMITED TO 4L/MONTH

Miscellaneous Gastrointestinal Supplies

\$\$	Ostomy Supplies
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Miscellaneous Gastrointestinal Agents

\$\$	Sulfasalazine	AZULFIDINE
\$\$\$\$	Mesalamine	ASACOL
		ROWASA
PA	\$\$\$\$	DIPENTUM
PA	\$\$\$\$\$	ENTOCORT EC, PA REQ

ANTI-INFECTIVE AGENTS

Amebicides

\$	Metronidazole	FLAGYL; FLAGYL ER NON-FORMULARY
\$\$\$	Iodoquinol (Diiodohydroxyquin)	YODOXIN

Antihelmintic Agents

\$	Mebendazole	VERMOX
\$\$	Furazolidone	FUROXONE
\$\$\$	Albendazole	ALBENZA

\$\$\$\$ Praziquantel

BILTRICIDE

Antibiotic Agents

Aminoglycosides

\$\$ Neomycin Sulfate

MYCIFRADIN

Cephalosporins

QL \$ Cephalexin
 \$\$ Cefixime
 \$\$\$ Cefaclor
 \$\$\$ Cefadroxil
SE, QL \$\$\$ Cefdinir

KEFLEX; **750MG STRENGTH NON-FORMULARY**
SUPRAX, LIMITED TO #1 X 400MG/FILL
CECLR
DURICEF
OMNICEF, **STEP THERAPY**, LIMITED TO 10-DAY SUPPLY,
RESTRICTED TO USE AFTER A TRIAL OF AN UNRESTRICTED
ANTIBIOTIC IN THE PAST 90 DAYS

Macrolide Antibiotic Agents

QL \$ Erythromycin Stearate
 \$ Erythromycin Base

 \$ Erythromycin Ethylsuccinate

QL \$\$ Azithromycin

PA \$\$ Erythromycin/Sulfisoxazole
 \$\$\$ Clarithromycin

ERYTHROCIN
ERY-TAB
PCE
EES
ERYPED SUSPENSION
ZITHROMAX, LIMITED TO A 5-DAY SUPPLY; **ZMAX NON-FORMULARY**
PEDIAZOLE
BIAXIN, **PA REQ**

Miscellaneous Antibiotic Agents

QL \$ Metronidazole
 \$\$ Clindamycin

Penicillins
QL \$ Amoxicillin

 \$ Ampicillin
 \$ Penicillin VK (125mg Tablets Not
 Covered)
SE, QL \$\$ Amoxicillin/Potassium Clavulanate

 \$\$ Dicloxacillin

FLAGYL
CLEOCIN

AMOXIL
TRIMOX
PRINCIPEN
PEN VK

AUGMENTIN, **STEP THERAPY**, LIMITED TO 10-DAY SUPPLY,
RESTRICTED TO USE AFTER A TRIAL OF AN UNRESTRICTED
ANTIBIOTIC IN THE PAST 90 DAYS
DYNAPEN

Quinolones

QL \$\$ Ciprofloxacin tablets

QL \$\$\$\$ Moxifloxacin

CIPRO TABLETS ONLY, LIMITED TO 21-DAY SUPPLY; **CIPRO XR AND PROQUIN XR NONFORMULARY**
AVELOX, LIMITED TO 21-DAY SUPPLY

Sulfonamide Agents

QL \$ Sulfamethoxazole/Trimethoprim
 (SMZ/TMP)
 \$ Trimethoprim
 \$\$ Erythromycin/Sulfisoxazole
 \$\$ Sulfisoxazole
 \$\$\$\$\$ Sulfadiazine

BACTRIM
SEPTRA
TRIMPEX
PEDIAZOLE
GANTRISIN
SULFADIAZINE

Tetracyclines

QL \$ Doxycycline

 \$ Tetracycline

 \$\$ Minocycline

VIBRAMYCIN
VIBRA-TABS
DORYX, PERIOSTAT, AND ORACEA NON-FORMULARY
ACHROMYCIN V
SUMYCIN
MINOCIN

Antifungal Agents

\$	Fluconazole	DIFLUCAN
\$	Ketoconazole	NIZORAL
\$	Nystatin (Oral Powder Not Covered)	MYCOSTATIN
\$\$	Clotrimazole	MYCELEX TROCHE
\$\$	Griseofulvin Ultramicrosized	GRIS-PEG
		FULVICIN P/G

Antimalarial Agents

\$	Chloroquine Phosphate	CHLOROQUINE PHOSPHATE
\$	Primaquine	PRIMAQUINE
\$	Quinine (260mg Not Covered)	QUININE
\$	Hydroxychloroquine	PLAQUENIL
\$\$	Mefloquine	LARIAM
\$\$	Pyrimethamine	DARAPRIM
\$\$\$	Iodoquinol	YODOXIN
\$\$\$\$	Atovaquone/Proguanil	MALARONE

Antituberculosis Agents

\$	Isoniazid	ISONIAZID
\$\$	Rifampin	RIFADIN
\$\$\$	Ethambutol	MYAMBUTOL
\$\$\$	Pyrazinamide	PYRAZINAMIDE
\$\$\$\$	Rifabutin	MYCOBUTIN

Anti-Ulcer Eradication Agents

QL	\$\$\$\$	Amoxicillin/Clarithromycin/Lansoprazole	PREVPAC, LIMITED TO 14-DAY SUPPLY/YEAR
QL	\$\$\$\$	Tetracycline/Bismuth/Metronidazole	HELIDAC, LIMITED TO 14-DAY SUPPLY/YEAR

Hepatitis C Antiviral Agents

CMSP Members Only: Evidence of ineligibility for the drug manufacturers' patient assistance program must be completed by the manufacturer and submitted to MedImpact for consideration of coverage of ribavirin and pegylated interferon. Additional information about drug company patient assistance programs is available on the internet at www.pparx.org. All other clinical prior authorization requirements remain in effect.

Path2Health members are not required to apply for the manufacturers' patient assistance program for ribavirin and pegylated interferon but must receive prior authorization approval to ensure clinical appropriateness.

PA	\$\$\$\$\$	Ribavirin	COPEGUS, REBETOL, PA REQ
PA	\$\$\$\$\$	Peginterferon Alfa 2b	PEG-INTRON, PA REQ , PEGASYS NON-FORMULARY

Victrelis (boceprevir) and Incivek (telaprevir) are not a covered benefit for both Path2Health and CMSP members. These agents may be available through the manufacturers' patient assistance program. Additional information about drug company patient assistance programs is available on the internet at www.pparx.org.

HIV Antiretroviral Agents

CMSP Members Only: CMSP requires evidence of ADAP ineligibility for antiretroviral coverage. Contact ADAP at (888) 311-7632 or (888) 575-2327 for more information. A Record of Denied Program Eligibility form must be completed and submitted to CMSP for antiretroviral coverage. This form can be obtained on the CMSP website: www.cmspcounties.org

Path2Health members are not required to apply ADAP.

	Abacavir Sulfate	ZIAGEN
	Abacavir Sulfate/Lamivudine	EPZICOM
	Abacavir/Lamivudine/Zidovudine	TRIZIVIR
	Darunavir Ethanolate	PREZISTA
	Delavirdine Mesylate	SCRIPTOR
	Didanosine	VIDEX
		VIDEX EC
	Efavirenz	SUSTIVA
	Efavirenz/Emtricitab/Tenofovir	ATRIPLA
	Emtricitab/Rilpivirine/Tenofovir	COMPLERA
	Emtricitabine	EMTRIVA
	Emtricitabine/Tenofovir	TRUVADA
	Etravirine	INTELENCE
	Fosamprenavir Calcium	LEXIVA
	Indinavir Sulfate	CRIVAN
	Lamivudine	EPIVIR
	Lamivudine/Zidovudine	COMBIVIR
	Lopinavir/Ritonavir	KALETRA
	Maraviroc	SELZENTRY
	Nelfinavir Mesylate	VIRACEPT
	Nevirapine	VIRAMUNE
		VIRAMUNE XR
	Raltegravir Potassium	ISENTRESS
	Rilpivirine HCl	EDURANT
	Ritonavir	NORVIR
	Saquinavir Mesylate	INVIRASE
	Stavudine	ZERIT
	Tenofovir Disoproxil Fumarate	VIREAD
	Tipranavir	APTIVUS
	Zidovudine	RETROVIR
PA	Enfuvirtide	FUZEON, PA REQ

Other Antiviral Agents

\$	Amantadine	SYMMETREL	
\$	Acyclovir Oral	ZOVIRAX ORAL	
\$\$	Rimantadine	FLUMADINE	
\$\$\$	Oseltamivir	TAMIFLU, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT OF EITHER TAMIFLU OR RELENTA PER 6 MONTHS	
\$\$\$	Zanamivir	RELENZA, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT OF EITHER RELENZA OR TAMIFLU PER 6 MONTHS	
SE	\$\$\$	Famciclovir	FAMVIR, STEP THERAPY, RESTRICTED TO USE AFTER A TRIAL OF ACYCLOVIR IN THE PAST 90 DAYS
SE	\$\$\$\$	Valacyclovir	VALTREX, STEP THERAPY, RESTRICTED TO USE AFTER A TRIAL OF ACYCLOVIR IN THE PAST 90 DAYS

Leprostatic Agents

\$ Clofazimine
\$ Dapsone

LAMPRENE
DAPSONE; ACZONE NON-FORMULARY

ANTINEOPLASTIC, IMMUNOMODULATOR, BLOOD COLONY STIMULATING FACTOR AND IMMUNOSUPPRESSANT AGENTS

Antineoplastic Agents

All oral, non-experimental antineoplastic agents are considered a formulary benefit.

PA	Altretamine	HEXALEN
	Anastrozole	ARIMIDEX
	Bexarotene	TARGRETIN
	Bicalutamide	CASODEX
	Busulfan	MYLERAN
	Capecitabine	XELODA
	Chlorambucil	LEUKERAN
	Cyclophosphamide	CYTOXAN
	Estramustine	EMCYT
	Etoposide	VEPESID
	Flutamide	EULEXIN
	Hydroxyurea	HYDREA
	Imatinib	GLEEVEC, PA REQ
	Letrozole	FEMARA
	Levamisole	ERGAMISOL
	Lomustine	CEENU
	Megestrol	MEGACE
	Melphalan	ALKERAN
	Mercaptourine	PURINETHOL
	Methotrexate	RHEUMATREX
	Mitotane	LYSODREN
	Nilutamide	NILANDRON
	Procarbazine	MATULANE
	Tamoxifen Citrate	NOLVADEX
	Testolactone	TESLAC
	Thioguanine	THIOGUANINE
	Tretinoin	VESANOID

Blood Colony Stimulating Factors

PA	\$\$\$\$\$	Darbepoetin	ARANESP, PA REQ
PA	\$\$\$\$\$	Erythropoietin	EPOGEN, PA REQ
PA			PROCRIT, PA REQ
PA	\$\$\$\$\$	Filgrastim	NEUPOGEN, PA REQ
PA	\$\$\$\$\$	Oprelvekin	NEUMEGA, PA REQ
PA	\$\$\$\$\$	Pegfilgrastim	NEULASTA, PA REQ
PA	\$\$\$\$\$	Sargramostim	LEUKINE, PA REQ

Multiple Sclerosis Agents

PA	\$\$\$\$\$	Glatiramer	COPAXONE, PA REQ
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PA	\$\$\$\$\$	Interferon Beta 1a	AVONEX, PA REQ
PA	\$\$\$\$\$	Interferon Beta 1b	REBIF, PA REQ
PA	\$\$\$\$\$		BETASERON, PA REQ

Miscellaneous Agents

PA	\$\$\$\$\$	Adalimumab	HUMIRA, PA REQ
PA	\$\$\$\$\$	Anakinra	KINERET, PA REQ
PA	\$\$\$\$\$	Etanercept	ENBREL, PA REQ
PA	\$\$\$\$\$	Interferon Alfa 2a	ROFERON A, PA REQ
PA	\$\$\$\$\$	Interferon Alfa 2b	INTRON A, PA REQ
PA	\$\$\$\$\$	Interferon Alfa N3	ALFERON N, PA REQ
PA	\$\$\$\$\$	Interferon Alfacon 1	INFERGEN, PA REQ
PA	\$\$\$\$\$	Interferon Gamma 1b	ACTIMMUNE, PA REQ
PA	\$\$\$\$\$	Leuprolide	LUPRON, PA REQ

Immunosuppressant Agents

\$	Leucovorin	WELLCOVORIN
\$\$	Azathioprine	IMURAN; AZASAN NON-FORMULARY
\$\$\$\$	Cyclosporine	NEORAL SANDIMMUNE
\$\$\$\$	Mycophenolate Mofetil	CELLCEPT ; MYFORTIC NON-FORMULARY
\$\$\$\$	Sirolimus	RAPAMUNE
\$\$\$\$	Tacrolimus (Oral only)	PROGRAF

RESPIRATORY/EENT AGENTS

Antihistamine Agents

Single Entity Alkylamine Agents

\$	Chlorpheniramine	CHLORTRIMETON
\$	Dexchlorpheniramine	POLARAMINE

Single Entity Ethanolamine Agents

\$	Cyproheptadine	PERIACTIN
\$	Diphenhydramine	BENADRYL

Non-Sedating Single Entity Agents

\$	Cetirizine, OTC	CETIRIZINE, OTC
\$	Loratadine, OTC	LORATADINE, OTC
\$\$	Fexofenadine	FEXOFENADINE, PA REQ

Miscellaneous Antihistamine Agents

\$	Hydroxyzine	ATARAX
\$	Hydroxyzine Pamoate	VISTARIL
\$	Promethazine	PHENERGAN

Antihistamine/Decongestant Combination Agents

Antihistamine/Decongestant Agents

\$	Bromphen/Pseudoephedrine	BROMFED
\$	Guaifenesin/Pseudoephedrine	GUAIFED-PD
\$	Pseudoephedrine/Chlorpheniramine	DECONAMINE SR
\$	Bromphen/Pseudoephedrine	BROMFED PD

Antitussive Agents

Non-Narcotic Antitussive Agents

\$	Benzonatate	TESSALON
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\$	Dextromethorphan	TUSSIN PEDIATRIC
\$	Promethazine/Dextromethorphan	PHENERGAN W/DEXTROMETHORPHAN
Narcotic Antitussive Agents		
\$	Codeine/Chlorpheniramine/ Pseudoephedrine	NOVAHISTINE DH
\$	Guaifenesin/Codeine	ROBITUSSIN A-C
\$	Guaifenesin/Codeine/Pseudoephedrine	NOVAHISTINE EXPECTORANT ROBITUSSIN DAC
\$	Phenylephrine/Hydrocodone/ Chlorpheniramine	HISTUSSIN HC ENDAL-HD
\$	Promethazine/Codeine	PHENERGAN/CODEINE
\$	Promethazine/Phenylephrine/Codeine	PHENERGAN VC/CODEINE
\$	Terpin Hydrate/Codeine	TERPIN HYDRATE/CODEINE
\$	Triprolidine/Pseudoephedrine/Codeine	ACTIFED/CODEINE
Decongestants		
\$	Pseudoephedrine	SUDAFED

Asthma/COPD Agents

Inhaled Sympathomimetic (Adrenergic) Agents

QL	\$\$	Albuterol HFA	PROVENTIL HFA , LIMITED TO #2 INHALERS/MONTH, PROAIR HFA, VENTOLIN HFA, AND XOPENEX HFA NON-FORMULARY.
QL	\$\$\$	Albuterol/Ipratropium	COMBIVENT, LIMITED TO #2 INHALERS/MONTH
QL	\$\$\$	Formoterol	FORADIL, LIMITED TO #60/MONTH
QL	\$\$\$	Ipratropium	ATROVENT HFA
QL	\$\$\$	Pirbuterol Acetate	MAXAIR, LIMITED TO #2 INHALERS/MONTH
QL	\$\$\$	Salmeterol	MAXAIR AUTOHALER, LIMITED TO #2 INHALERS/MONTH SEREVENT, LIMITED TO #1 INHALER/MONTH OR #60 BLISTERS/MONTH
SE, QL	\$\$\$\$	Mometasone/Formoterol	DULERA, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF ORAL INHALED STEROID (IF ASTHMA) OR ANTICHOLINERGIC/LABA (IF COPD) IN THE PAST 90 DAYS, LIMITED TO #1 INHALER/MONTH
SE, QL	\$\$\$\$	Salmeterol/Fluticasone	ADVAIR DISKUS, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF ORAL INHALED STEROID (IF ASTHMA) OR ANTICHOLINERGIC/LABA (IF COPD) IN THE PAST 90 DAYS, LIMITED TO #60/MONTH
SE, QL	\$\$\$\$	Salmeterol/Fluticasone	ADVAIR HFA , STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF ORAL INHALED STEROID (IF ASTHMA) OR ANTICHOLINERGIC/LABA (IF COPD) IN THE PAST 90 DAYS, LIMITED TO 2 INHALERS/MONTH

Oral Sympathomimetic (Adrenergic) Agents

\$	Albuterol	PROVENTIL
\$	Metaproterenol Oral	ALUPENT
\$\$	Terbutaline Sulfate	BRETHINE
		BRICANYL
\$\$	Albuterol E.R.	PROVENTIL REPETABS VOLMAX

Inhaled Oral Corticosteroid Agents

QL	\$\$	Beclomethasone Inhaler	QVAR, LIMITED TO #2 INHALERS/MONTH
QL	\$\$\$	Mometasone Inhaler	ASMANEX, LIMITED TO #2 INHALERS/MONTH

Leukotriene Receptor Antagonists

QL	\$\$\$	Montelukast	SINGULAIR, LIMITED TO #30/MONTH
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Respiratory Smooth Muscle Relaxant Agents

\$	Aminophylline 150mg/5ml	
\$	Aminophylline Suppositories	
\$	Theophylline, 80mg/15cc (Alcohol Free)	SLO-PHYLLIN 80
\$\$	Theophylline	SLO-PHYLLIN
\$\$	Theophylline, Sustained Release	THEO-DUR, SLO-BID, UNIPHYL

Expectorant Agents

\$	Guaifenesin	ROBITUSSIN
\$	Guaifenesin/Dextromethorphan	ROBITUSSIN DM
\$	Guaifenesin/Phenylephrine	ENDAL
\$	Guaifenesin/Pseudoephedrine	ZEPHREX LA
\$	Phenylephrine/Promethazine	PHENERGAN VC
\$\$	Phenylephrine/Guaifenesin	RESCON GC
\$\$	Potassium Iodide	SSKI

Mucolytic Agents

\$\$\$	Acetylcysteine	MUCOMYST
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Eye, Ear, Nose and Throat (EENT) Preparations

Ophthalmic Antibiotic Agents

\$\$	Bacitracin	BACITRACIN
\$	Dexamethasone/Polymyxin/Neomycin	MAXITROL
\$	Erythromycin Base	ILOTYCIN
\$	Neomycin/Gramicidin/Polymyxin	NEOSPORIN OPHTHALMIC
\$	Gentamicin	GARAMYCIN
\$\$	Hydrocortisone/Neomycin/Polymyxin	CORTISPORIN OPHTHALMIC
\$\$	Tobramycin	TOBREX
\$\$	Neomycin/Polymyxin/Prednisone	POLY-PRED
\$	Polymixin B Sulfate/TMP	POLYTRIM
\$\$	Gentamicin/Prednisolone	PRED-G
\$	Ofloxacin	OCUFLOX

Ophthalmic Anti-Inflammatory Agents, Corticosteroid

\$	Fluorometholone	EFLONE
		FML
		FML FORTE
\$\$	Prednisolone Acetate	PRED MILD OPHTHALMIC
\$	Prednisolone Phosphate	PRED FORTE
		INFLAMASE
		INFLAMASE FORTE

Ophthalmic Anti-Inflammatory Agents, NSAIDs

\$	Flurbiprofen Sodium	OCUFEN
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\$\$	Diclofenac Sodium	VOLTAREN
\$\$	Ketorolac Tromethamine	ACULAR
Ophthalmic Antiviral Agents		
\$\$\$	Trifluridine Ophthalmic Solution	VIROPTIC
Ophthalmic Beta Blockers		
\$	Timolol	TIMOPTIC
\$\$	Levobunolol	BETAGAN
\$\$	Timolol	TIMOPTIC-XE
\$\$\$	Betaxolol	BETOPTIC
\$\$\$	Timolol	BETIMOL
Ophthalmic Miotic Agents		
\$	Pilocarpine	PILOCAR OCUSER NOT COVERED
\$\$	Brimonidine	ALPHAGAN
\$\$	Dorzolamide	TRUSOPT
\$\$\$	Brimonidine	ALPHAGAN P
\$\$\$	Dorzolamide/Timolol	COSOPT
\$\$\$	Echothiophate Iodide	PHOSPHOLINE IODIDE
Ophthalmic Mydriatic Agents		
\$	Atropine Sulfate	ISOPTO ATROPINE
\$	Tropicamide	MYDRIACYL
\$\$	Dipivefrin	PROPINE
Ophthalmic Sulfonamide Agents		
\$	Sulfacetamide	BLEPH-10 SODIUM SULAMYD
\$\$\$	Sulfacetamide 10%/Prednisolone 0.2%	BLEPHAMIDE
\$\$\$\$	Sulfacetamide 10%/Prednisolone 0.5%	METIMYD
Miscellaneous Ophthalmic Agents		
\$	Naphazoline	ALBALON
\$	Naphazoline/Pheniramine	NAPHCON-A
\$	Ketotifen	ZADITOR OTC, ALAWAY
\$\$\$	Latanoprost	XALATAN
Otic Anti-Infective Agents		
\$\$	Acetic Acid	VOSOL
\$\$	Acetic Acid 2%	DOMEBORO
\$\$	Hydrocortisone/Neomycin/Polymyxin	CORTISPORIN
\$\$	Ofloxacin	FLOXIN OTIC
\$\$\$	Acetic Acid 2%/Hydrocortisone 1%	VOSOL HC
Miscellaneous Otic Agents		
\$	Carbamide Peroxide/Glycerin	DEBROX
\$\$\$\$	Benzocaine/Antipyrine	AURALGAN

Inhaled/Oral EENT Agents

QL	Inhaled Nasal Agents	
	\$\$	Ipratropium, Nasal
Carbonic Anhydrase Inhibitor Agents		
\$\$	Acetazolamide	DIAMOX
\$\$\$	Acetazolamide SA	DIAMOX SEQUELS
\$\$\$	Methazolamide	NEPTAZANE
Local Anesthetic Agents		
\$	Lidocaine Solution	XYLOCAINE
\$	Lidocaine, Viscous	VISCOUS XYLOCAINE
\$\$	Benzocaine/Antipyrine Otic	AURALGAN
\$\$\$	Triamcinolone 0.1% in Orabase	KENALOG IN ORABASE

Miscellaneous EENT Agents

	\$	Sodium Chloride for Inhalation	GENERIC
	\$\$	Carbachol	ISOPTO CARBACHOL
	\$\$	Chlorhexidine Gluconate	PERIDEX
	\$\$	Epinephrine Injection	EPIPEN
QL	\$\$	Optichamber	OPTICHAMBER, LIMITED TO #2/YEAR
	\$\$\$	Triethanolamine	CERUMENEX
	\$\$\$\$	Cromolyn Ophthalmic Solution	CROLOM
QL	\$\$\$\$	Cromolyn Sodium	INTAL INHALER, LIMITED TO #2 INHALERS/MONTH
QL	\$\$\$\$	Nedocromil Sodium	TILADE INHALER, LIMITED TO #2 INHALERS/MONTH

DIABETES AND THYROID AGENTS

Oral Diabetes Agents

Sulfonylureas

	\$	Acetohexamide	DYMELOR
	\$	Chlorpropamide	DIABINESE
	\$	Glipizide	GLUCOTROL
	\$	Glyburide	DIABETA, GLYNASE
	\$		MICRONASE
	\$	Glimepiride	AMARYL
	\$	Tolazamide	TOLINASE
	\$	Tolbutamide	ORINASE
SE	\$\$	Glipizide L.A.	GLUCOTROL XL, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF GLIPIZIDE IN THE PAST 90 DAYS

Non-Sulfonylureas

	\$	Metformin	GLUCOPHAGE
	\$	Metformin ER	GLUCOPHAGE XR
	\$\$\$\$	Acarbose	PRECOSE
SE	\$\$\$\$\$	Pioglitazone	ACTOS, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF METFORMIN IN THE PAST 365 DAYS , LIMITED TO 30 TABLETS/MONTH
SE, QL	\$\$\$\$\$	Sitagliptin	JANUVIA, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF METFORMIN IN THE PAST 365 DAYS , LIMITED TO 30 TABLETS/MONTH

Combination Diabetes Agents

	\$\$	Glipizide/Metformin	METAGLIP
	\$\$	Glyburide/Metformin	GLUCOVANCE
SE, QL	\$\$\$\$\$	Sitagliptin/Metformin	JANUMET, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF METFORMIN OR JANUVIA IN THE PAST 365 DAYS, LIMITED TO 60 TABLETS/MONTH

Insulin Agents

\$\$\$	Insulin	ALL LILLY INSULINS, VIALS ONLY
\$\$\$\$	Insulin Lispro	HUMALOG, HUMALOG MIX, VIALS AND PENS
\$\$\$\$	Insulin Glargine	LANTUS, VIALS ONLY

Miscellaneous Diabetes Agents

\$\$\$	Glucagon	GLUCAGON
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Thyroid Agents

\$	Thyroid, Desiccated	ARMOUR THYROID
\$\$	Levothyroxine	LEVOTHROID LEVOXYL SYNTHROID THYROLAR CYTOMEL
\$\$	Liotrix	
\$\$\$	Liothyronine	
Antithyroid Agents		
\$\$	Propylthiouracil	PROPYLTIOURACIL
\$\$\$	Methimazole	TAPAZOLE

HORMONE AGENTS

Oral Adrenal Corticosteroid Agents

\$	Dexamethasone	DECADRON
\$	Hydrocortisone Oral	CORTEF
\$	Prednisone	DELTASONE ORASONE
\$\$	Cortisone Acetate	CORTONE
\$\$	Fludrocortisone Acetate	FLORINEF
\$\$	Methylprednisolone	MEDROL MEDROL DOSEPAK
\$\$	Prednisolone	PEDIAPRED PRELONE

Androgen Agents

\$\$	Fluoxymesterone	HALOTESTIN
\$\$	Methyltestosterone	ANDROID METANDREN
\$\$\$\$	Danazol	DANOCRINE

Bone Resorption Inhibitors

QL	\$\$	Alendronate	FOSAMAX, 70MG AND 35MG LIMITED TO #4/MONTH; 5MG, 10MG, AND 40MG LIMITED TO #30/MONTH; SOLUTION LIMITED TO #300ML/MONTH FOSAMAX PLUS D NONFORMULARY MIACALCIN NS, PA REQ
PA	\$\$\$\$	Calcitonin	

Parathyroid Hormone

PA, QL	\$\$\$\$	Teriparatide	FORTEO, PA REQ, LIMITED TO 1 PEN/MONTH
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Estrogen Agents

\$	Diethylstilbestrol	DES	
\$	Estradiol	ESTRACE	
\$\$	Conjugated Estrogens	PREMARIN	
\$\$	Conjugated Estrogens, Vaginal	PREMARIN VAGINAL CREAM	
SE	\$\$	Estradiol/Vaginal Ring	ESTRING, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF PREMARIN VAGINAL CREAM IN THE PAST 90 DAYS

\$\$	Estrogen/Medroxyprogesterone	PREMPRO, PREMPRO LOW DOSE PREMPHASE
\$\$	Esterified Estrogens/ Methyltestosterone	ESTRATEST, ESTRATEST HS
\$\$\$	Estradiol Patches	ALORA CLIMARA ESTRADERM VIVELLE VIVELLE DOT
Estrogen Agonist-Antagonists		
\$\$\$\$	Raloxifene	EVISTA

Oral Contraceptive Agents

Path2Health does not provide contraceptive coverage. Contact Family PACT at (800) 942-1054 for more information.

CMSP requires evidence of Family PACT ineligibility for contraceptive coverage. Contact Family PACT at (800) 942-1054 for more information. A Record of Denied Program Eligibility form must be completed and submitted to MedImpact for contraceptive coverage. This form can be obtained on the CMSP website: www.cmspcounties.org.

Oxytocic Agents

\$\$	Ergonovine Maleate	ERGOTRATE
\$\$	Methylergonovine Maleate	METHERGINE

Pituitary Agents

\$\$\$\$	Desmopressin	DDAVP
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Progestin Agents

\$\$	Medroxyprogesterone	CYCRIN PROVERA
\$\$	Norethindrone Acetate	AYGESTIN NORLUTATE

GENITOURINARY AGENTS

Urinary Anti-Infective Agents

\$	Trimethoprim	TRIMPEX
\$\$	Meth/Me Blue/PA/Salol/ATP/Hyos	URISED
\$\$\$	Nitrofurantoin (Tablets, Suspension Only)	FURADANTIN

Urinary Anti-Spasmodic Agents

\$	Phenazopyridine	PYRIDIUM
\$\$\$	Pentosan	ELMIRON

Genitourinary Smooth Muscle Relaxant Agents

\$\$	Belladonna/Methylene Blue	URISED
\$\$	Oxybutynin	DITROPAN DITROPAN XL NOT COVERED

ST, QL	\$\$\$\$	Tolterodine	DETROL, STEP THERAPY , LIMITED TO #60/MONTH, RESTRICTED TO USE AFTER A TRIAL OF OXYBUTININ IN THE PAST 90 DAYS
ST, QL			DETROL LA, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF OXYBUTININ IN THE PAST 90 DAYS

Parasympathomimetic (Cholinergic) Agents

\$	Bethanechol	URECHOLINE
\$	Neostigmine	PROSTIGMIN
\$	Pyridostigmine	MESTINON

TOPICAL/MUCOUS MEMBRANE AGENTS

Keratolytic Agents

\$	Anthralin	DRITHOCREME
\$\$\$	Podofilox	DRITHO-SCALP CONDYLOX

Miscellaneous Skin/Mucous Membrane Agents

\$	Aluminum Acetate	BURROWS SOLUTION
\$	Benzoyl Peroxide, OTC Generic	BENZOYL PEROXIDE, OTC GENERIC
\$	Calamine	CALAMINE LOTION
\$	Hydrocortisone 1% Rectal	PROCTOCORT
\$\$	Aluminum Chloride Hexahydrate	DRYSOL
\$\$	Calcipotriene	DOVONEX
\$\$	Fluorouracil	EFUDEX
\$\$	Masoprolac	ACTINEX
PA	\$\$\$ Isotretinoin	ACUTANE, PA REQ
PA	\$\$\$\$\$ Bepacplermin	REGRANEX, PA REQ

Topical Antibiotic Agents

\$	Bacitracin	BACITRACIN
\$	Bacitracin/Polymixin/Neomycin	NEOSPORIN
\$	Erythromycin Topical	ERYGEL EMGEL T-STAT
\$\$	Clindamycin Solution	CLEOCIN T
\$\$	Gentamicin Sulfate	GARAMYCIN
\$\$\$	Erythromycin/Benzoyl Peroxide	BENZAMYCIN
\$\$\$	Silver Sulfadiazine	SILVADENE
\$\$\$\$	Mupirocin	BACTROBAN

Topical Antifungal Agents

\$	Nystatin	MYCOSTATIN
\$	Tolnaftate	TINACTIN
\$	Triamcinolone/Nystatin	MYCOLOG II
\$\$\$	Ciclopirox	LOPROX
\$\$\$	Clotrimazole	LOTRIMIN
\$\$\$	Clotrimazole/Betamethasone	LOTRISONE
\$\$\$	Ketoconazole	NIZORAL
\$\$\$	Miconazole Nitrate	MONISTAT-DERM

\$\$\$	Terbinafine	LAMISIL (TOPICAL ONLY), TABLETS AND GRANULES NON-FORMULARY
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Vaginal Antifungal Agents

\$	Clotrimazole Cream/Vaginal Tablets	MYCELEX MYCELEX G
\$	Nystatin	MYCOSTATIN
\$\$	Butoconazole	FEMSTAT
\$\$	Miconazole Cream/Vaginal Tablets	MONISTAT MONISTAT 3
\$\$	Triple Sulfa Cream	SULTRIN
\$\$\$	Tioconazole	VAGISTAT-1

Vaginal Anti-Infective Agents

\$\$\$	Metronidazole	METROGEL-VAGINAL
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Topical Contraceptive Agents

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Topical Anti-Inflammatory Agents

LOW POTENCY		
\$	Fluocinolone 0.025%	SYNALAR
\$	Hydrocortisone	HYTONE
\$\$	Desonide	TRIDESILON
\$\$	Hydrocortisone Acetate	CORTIFOAM
\$\$	Hydrocortisone/Pramoxine	PROCTOCREAM-HC
\$\$\$\$	Hydrocortisone Enema	CORTENEMA
MEDIUM POTENCY		
\$	Betamethasone Dipropionate	DIPROSONE MAXIVATE
\$	Betamethasone Valerate 0.01%	VALISONE REDUCED STRENGTH
\$	Betamethasone Valerate 0.1%	VALISONE
\$	Triamcinolone	ARISTOCORT ARISTOCORT A NOT COVERED KENALOG
\$\$\$	Desoximetasone Cream/Gel 0.05%	TOPICORT LP
\$\$\$	Flurandrenolide	CORDRAN
\$\$\$	Hydrocortisone Valerate	WESTCORT
\$\$\$	Mometasone Furoate Cream	ELOCON
HIGH POTENCY		
\$\$	Desoximetasone 0.25%	TOPICORT
\$\$	Fluocinonide	LIDEX LIDEX E
\$\$	Fluocinolone Acetonide 0.2%	SYNALAR
\$\$\$	Betamethasone Dipropionate	DIPROLENE
VERY HIGH POTENCY		
\$\$	Clobetasol Cream, Gel, Solution, Ointment	TEMOVATE

\$\$\$\$	Augmented Betamethasone Dipropionate	DIPROLENE AF
\$\$\$\$	Diflorasone Diacetate	FLORONE FLORONE-E PSORCON

Topical Antipruritic and Local Anesthetic Agents

\$\$	Lidocaine (Viscous and Spray Only)	XYLOCAINE
\$\$	Pramoxine/Hydrocortisone	PROTOFOAM HC
\$\$\$	Pramoxine	EPIFOAM
PA \$\$\$\$	Pimecrolimus	ELIDEL, PA REQ

Topical Antiviral Agents

\$\$\$\$	Acyclovir Topical	ZOVIRAX OINTMENT
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Topical Miscellaneous Anti-Infective Agents

\$	Selenium Sulfide 2.5%	EXSEL
\$	Sulfacetamide Lotion	SELSUN SEBIZON

Scabicide/Pediculicide Agents

\$\$\$	Crotamiton	EURAX
\$\$\$	Malathion	OVIDE
\$\$\$	Permethrin	ELIMITE NIX

MISCELLANEOUS/UNCLASSIFIED AGENTS

Electrolyte Agents

Miscellaneous Agents

\$	Calcium Carbonate	TUMS
\$	Magnesium Oxide, OTC Generic	MAGNESIUM OXIDE, OTC GENERIC
\$\$	Calcium Acetate	PHOS LO
\$\$	Electrolyte Solution, Pediatric Oral	PEDIALYTE

Potassium Agents

<i>Potassium Chloride 8mEq</i>		
\$\$	Potassium Chloride	
<i>Potassium Chloride 10mEq</i>		
\$\$	Potassium Chloride	MICRO-K
		KAON-CL 10
		K-DUR
		MICRO-K 10
<i>Potassium Chloride 20mEq</i>		
\$\$	Potassium Chloride	K-DUR

<i>Potassium Chloride Effervescent Tablets</i>	
\$ Potassium Chloride Tablets	K-LYTE
\$\$ Potassium Chloride Tablets	K-LYTE CL DS
<i>Potassium Chloride Powders</i>	
\$\$ Potassium Chloride Powder	K-LOR
<i>Potassium Chloride Liquids</i>	
\$ Potassium Chloride Liquid	KAON-CL
<i>Potassium-Removing Resins</i>	
\$\$\$\$ Sodium Polystyrene Sulfonate	KAYEXALATE

Heavy Metal Antagonist Agents

\$\$\$\$ Penicillamine	CUPRIMINE
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Vitamin Agents

Vitamin B-Complex Agents

\$ Cyanocobalamin	VITAMIN B ₁₂ (ORAL FORMULATIONS ONLY)
\$ Folic Acid	FOLIC ACID
\$ Pyridoxine	VITAMIN B ₆
\$ Thiamine	VITAMIN B ₁
\$\$ Niacin	NIACIN

Vitamin D

\$\$\$ Calcitriol	ROCALTROL
\$\$\$ Ergocalciferol	DRISDOL

Vitamin K Activity Agents

\$\$ Phytonadione	MEPHYTON
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Iron Agents

\$ Ferrous Sulfate (Tablets, Liquid, Drops)	FEOSOL
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Diagnostic Testing

Blood Glucose Supplies

QL \$ Alcohol Swabs	LIMITED TO 200/MONTH
QL \$\$ Blood Glucose Monitoring Control Solution	BLOOD GLUCOSE MONITORING CONTROL SOLUTION, ROCHE PRODUCTS (E.G., ACCU-CHEK) ONLY
QL \$\$ Lancets	
QL \$\$\$ Blood Glucose Test Strips	BLOOD GLUCOSE TEST STRIPS, ROCHE STRIPS (E.G., ACCU-CHEK) ONLY, LIMITED TO 100 STRIPS/MONTH FOR MEMBERS THAT ARE DIET-CONTROLLED OR ON ORAL AGENTS. MEMBERS ON INSULIN LIMITED TO 150 STRIPS/MONTH. LARGER QUANTITIES AVAILABLE VIA PRIOR AUTHORIZATION
QL \$\$\$ Glucometers	GLUCOMETERS, ROCHE METERS (E.G., ACCU-CHEK) ONLY

Alcohol And Smoking Deterrent Agents

PA \$\$ Disulfiram	ANTABUSE
PA \$\$\$ Bupropion SR	ZYBAN, PA REQ
PA \$\$\$ Nicotine	NICORETTE GUM, PA REQ
PA	NICOTINE PATCH, PA REQ (OTC PATCHES ONLY)
PA	NICOTROL NASAL SPRAY, PA REQ

Gout Agents

\$\$ Probenecid	BENEMID
\$\$ Allopurinol	ZYLOPRIM

QL \$\$\$\$ Colchicine

COLCRYSTALS, LIMITED TO 1 TABLET/DAY. PATIENTS WHO FAIL 1 TABLET/DAY MAY RECEIVE 2 TABLETS/DAY.

Other Medical Supplies

Limited medical supplies are available through the pharmacy benefit. For additional information, contact MedImpact at (800) 788-2949. The following exceptions should be noted:

- Durable medical equipment (e.g., wheelchairs, walkers, canes, crutches) are filled through the medical benefit. Call Anthem Blue Cross at (800) 670-6133.
- Path2Health does not provide coverage for contraceptive medical supplies (e.g. diaphragms, cervical caps, condoms). Call Family PACT (800) 942-1054 for further information.
- CMSP does not provide coverage for contraceptive medical supplies (e.g., diaphragms, cervical caps, condoms) unless the member is ineligible for Family PACT. Call Family PACT (800) 942-1054. If ineligible, call MedImpact at (800) 788-2949.

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